STATE OF CONNECTICUT
State Innovation Model
Health Information Technology Council

Meeting Summary
Friday, June 17, 2016

Meeting Location: Legislative Office Building, Room 1C, 300 Capitol Avenue, Hartford

Members Present: Thomas Agresta; Patricia Checko; Jessica DeFlumer-Trapp; Anthony Dias; Michael Hunt; Mike Miller via conference line; Amanda Skinner; Victor Villagra

Members Absent: Roderick Bremby; Anne Camp; Tiffany Donelson; Ludwig Johnson; Vanessa Kapral; Matthew Katz; Alan Kaye; Mark Raymond; Philip Renda; Sheryl Turney; Josh Wojcik; Moh Zaman

Other Participants: Faina Dookh, Mark Schaefer; Minakshi Tikoo; Victoria Veltri

1. Introductions

The meeting was called to order at 10:02 a.m. Both co-chairs were unable to attend so Dr. Tikoo chaired the meeting. Members and participants introduced themselves.

2. Public Comment

There was no public comment.

3. Minutes Approval

Motion: to approve the minutes of the April 15, 2016 Health Information Technology Council meeting –Amanda Skinner; seconded by Victor Villagra.

Discussion: Dr. Villagra said he has an amendment to the third paragraph from the bottom on page three regarding his comments. He said the data in the handout is not clinical data but claim proxies for clinical data. He said that he would submit the amendment.

Vote: All in favor of approval of the minutes as amended.

4. HIT Ops Plan

Ms. Veltri provided a status update on the HIT Operational Plan (see meeting presentation here). She mentioned she is hoping the draft HIT Operational Plan (essentially a project narrative) will be distributed by next week. It is due to the feds in August. She noted that the plan is mostly focused on technologies for project year one – the Alert Notifications Engine, EMPI, and the Provider Directory. Ms. Veltri mentioned that this was the last meeting of the SIM HIT Council and that the HIT functions are being taken over by the statewide HIT Advisory Council.

5. Zato Demo Discussion

Dr. Tikoo provided an overview of the analysis on the Zato Demonstration and opened the floor for comments.

Ms. Skinner said that she did not have a favorable viewpoint of the platform, when she attended the demonstration. She said she did not feel confident that Zato has enough or any experience deploying in a healthcare setting. She mentioned that Zato talked about having worked with Baystate, however, she said that after talking with a couple of current employees of Baystate, the employees said that they did not have any knowledge of the platform. Her conclusion was that Zato is not being implemented at Baystate but is being piloted at TechSprings. This was based on her personal conversations with former YNHHS employees that work at Baystate now. Ms. Skinner expressed concern about Zato's ability to do data aggregation across platforms. She said it appears they can query an already combined data set, but not integrate separate data sets. She said she did not see examples of patient matching or the integration of data.

Ms. Skinner mentioned she did not feel that data security was demonstrated, nor was implementation within a healthcare system. She said there are many platforms already on the market that can combine claims and clinical data, run it through an integration platform, and do reporting out. Vendors have already demonstrated an ability to do this, and this includes large, well regarded tech firms. Ms. Skinner mentioned not being sure that we need as much customization they spoke of. She said from her perspective, there are other vendors that are demonstrating and articulating the customization as effectively, if not more.

Mr. Dias attended the second demo. Mr. Dias said that data integration is intended to reach into multiple data sources and integrate the data. He said this was not demoed and that the demo used one data source, from Baystate, and all queries were run on this one data set. Mr. Dias said he did not see Zato reaching into more than one data source. Additionally, this demonstration revealed significant duplication of queries that provide "unclean data." The look-up provides duplicates, which will be bad information. He said that it appears Zato has experience on the military side but is not sure of this relevance in healthcare.

Mr. Dias expressed concern that significant amount of work still needs to be done, and that there seems to be a lot of heavy lifting needed before this technology can be implemented. He mentioned an evaluation may be useful on how the Zato process is better than some of the other vendors. He said a slide deck was shown during the demonstration of how a clinical quality measure (CQM) would work. It wasn't clear on how they could look at the data, aggregate, and provide clean information.

Dr. Checko stated that in her assessment several questions went unaddressed, such as, the cost to the provider, along with the amount of time and the commitment of staff. Dr. Checko said she was disappointed in the platforms' ability to be used as an analytic tool beyond measuring quality measures at an average level and readiness for use. She said that it can address a quality measure without any cross tabs on it. She mentioned that it is too expensive a tool for this. Dr. Checko said there is a question of who owns the data. She said that at a single point in time the data is pulled,

and to replicate it you would have to repeat the entire search and analysis. She mentioned that although they have intriguing technology for down the road, they really need to show us how this could be used now. She expressed concerned regarding being too expensive.

Dr. Agresta stated that the Zato team never walked through how the data was aggregated, where it was stored, how to replicate it, and how it can integrate across two different organizations. He said he was looking for an explanation of how this happens and then a demo of it. He said he participated in the second demo but did not see identifiable data, only aggregated data. Dr. Agresta said Zato showed what they could do with one measure, but not more than one. He said from his perspective, the demo was challenging and frustrating.

Dr. Agresta stated that without patient matching numbers or an EMPI, if you set it up across more than one organization you would have to de-duplicate the data. He said that now that we are getting into HIE work, with data ending up in more than one place and duplication of data, there is a question of how Zato would manage that.

Dr. Checko said that there was no attempt to use any demographic data to take a look at the variables, and is disappointed they did not get into the use of demographic data to look at the variables in the second session.

Ms. DeFlumer-Trapp agreed with the point about customization. She said that the lift for Zato to program quality measures is high, especially when there are other products out there. She said scalability would be hard because whenever there is a change to the EHR there would be a feedback loop needed with the provider. Ms. DeFlumer-Trapp mentioned there was no systemic process in place to make updates when there are changes to the EHR.

Dr. Schaefer noted that there was a discrepancy between quantitative ratings in the Zato demonstration evaluation sheet and the comments being made. He asked whether the council wanted to leave what is being said as a collection of comments or vote for a definitive recommendation of the next step. Ms. Veltri noted that a quorum had not been reached so voting could not take place. She suggested that the comments be shared with the Statewide HIT Advisory Council.

Ms. Skinner mentioned that it would be appropriate to hear from the members that had the positive feedback. Dr. Tikoo read comments from a council member who commented that the demonstration went very well to help provide some balance. The positive comment noted that the demo was successful because the software provides the best example of interoperability that they've seen across a number of States. The positive comment noted that verifiability and auditability were really done well.

Ms. Veltri asked whether it was possible to share the written comments from the evaluation forms, without the names, with the group. She mentioned it would be helpful to have the comments compiled. Ms. Tikoo said yes.

Dr. Villagra commented that there should be additional clarity on the feedback. He said that the bar was higher in this demonstration in his opinion than any he had seen in the past. He said de-duplication and cross institutional integration is challenging. Dr. Villagra said because of potential implications of a 'down' recommendation, there is the question of what is our plan B, as other vendors have not been subjected to this rigor. Dr. Villagra mentioned that more nuance and comparability to other vendors will be informative. He said that one idea previously discussed was to send the clinical quality metric/ criteria to institutions so that they can begin testing them. He said they would be further ahead today if they had done that. Dr. Tikoo responded that the Quality Council is charged with the selection of the measures. Dr. Schaefer confirmed that there is a set that will be finalized in August.

Dr. Checko said there were at least the 2 or 3 final quality measures that were provided including the diabetes and hypertension measures.

Dr. Schaefer said that due to the lack of a quorum and the other council's role, he asked whether committee members that attended the demonstration that did not have a chance to fill out the form should be able to submit their comments. Dr. Tikoo said that giving a deadline is important. She said that attendees to the Zato Demonstration were asked for their feedback one week after attending. She said that the further you go from the time of the demo, the less people remember about it.

Mr. Dias suggested for a reminder to be sent today to fill out comments. Ms. Veltri suggested that council members be given until June 24, 2016 to submit comments. A reminder will be sent out to members who attended the session.

The demo was setup as a pre-step. Dr. Schaefer mentioned that no one commented on what they think should be the next steps.

Ms. Skinner suggested doing an RFP to spell out what is being looked for on paper and look at the right vendor and not the convenient one.

Dr. Villagra said it is important to have a global picture of what the options are. He suggested before they get into an RFP, they should think about what are the alternatives, at this stage.

Mr. Hunt asked regarding the use of the expertise of the SIM HIT Council and the membership of statewide HIT Advisory Council.

6. Legislative Update

Ms. Veltri provided an overview of why the state is moving forward with the merging of the councils. She gave an overview of P.A. 16-77, which requires the Lt. Governor to designate a health information technology officer (HITO). The state is undertaking the following tasks:

- The state will contract with a search firm to assist with developing the job specification, with a goal to onboard August 1, 2016.

- Between August & next year, the HITO will take on responsibility for chairing the Statewide HIT advisory council.
- The HITO will identify the vendor that will be responsible for facilitating the council meetings and conducting stakeholder engagement (see slides from meeting).
- The HITO will be responsible for drafting an RFP for HIE needs per Public Acts15-146 and 16-77.
- The HITO will establish a virtual HIT PMO that cuts across APCD, Medicaid, etc. -- not just SIM.
- The HITO will perform SIM reporting & other reporting.

The June statewide Health IT Advisory Council meeting was yesterday. At the statewide Council, members discussed the consolidation of both councils. The statewide council requested a summary of key findings of the SIM HIT Council as well as a summary of the HIE presentations that occurred at the beginning of 2016.

7. PMO Updates

Faina Dookh presented a quick update on the Quality Council. Notes from the slides included:

- Most aspects of the Quality Council's report are being finalized
- Purpose of the work: Development of a core set of quality measures to promote alignment of quality measures used in value-based payment arrangements in Connecticut.
    - The Council started with looking at the 120 measures in use at the state. They then went through a three stage process, where they de-duplicated, looked at public health priorities of Connecticut, health equity implications, and other.
    - They will continue to monitor the pace of alignment.

8. Q&A

Questions from Ms. Dookh's presentation, were from:
Dr. Villagra asked for the meaning of the equity column for the Provisional Core Measure Set slide. Ms. Dookh responded that there was a health equity design group that recommended some of the measures that related to areas in which there were significant health equity implications.

Ms. Skinner asked why PCMH CAHPS was on the recommended core quality measure set instead of CG CAHPS and whether this conflicts with what providers are currently using in the field. Dr. Schaefer said that there are many different versions of the CAHPS measure, and a changing landscape nationally as to what the national standard will be. The CG CAHPS measure was settled on because it was recently updated. PCMH and behavioral health items were then added as supplements. Dr. Schaefer noted that since the state is funding the administration of the CAHPS, it does not matter what providers are using in the field. As in Medicare SSP, Medicare funds the first wave and then providers take responsibility for administering it. So if it becomes a situation where providers take over the administration, then we might have to re-consider our strategy.

In addition, Dr. Schaefer indicated that the state is trying to come up with the most economic and efficient way to administer CAHPS. This means asking all of the plans to submit member files to a

vendor, capturing a single sample proportionate to the attributed lives for each payer. It would be very difficult for a provider in the field to select a sample of proportionate attributed lives. It is much more straightforward for the state to offer this service. We can reconsider what we do in the long-term, but over the next three years, that is the strategy.

Dr. Schaefer said initially ACO CAHPS was proposed, but this instrument only had national benchmark data for Medicare, and not commercial and Medicaid. We decided on PCMH CAHPS, and then CQMC announced they were endorsing the PCMH CAHPS, but then indicated they meant to endorse the ACO CAHPS. MIPS is endorsing the ACO CAHPS, which will substantially broaden the ACO CAHPS as the national standard. So it seems it is less likely for the MIPS measure to be CG CAHPS. He said that at the moment SIM is focused on the PCMH CAHPS, but as you can see there are a variety of reasons for us to recognize that this may not be the right measure for the long term.

Ms. Dookh circled back to a slide in the presentation, which listed the major topics that were discussed by the HIT Council, from 2014-2016. She asked the attendees what considerations should be shared with the Health IT Advisory Council.

Dr. Checko mentioned that the list didn't cover discussions the council has had around confidentiality and privacy, where the new HIE advisory group should really look at this because there are larger implications down the road. She also said that early on they spent a lot of time on access to Medicaid data. Ms. Veltri confirmed to her that an MOA has been signed between Medicaid and DSS for the APCD as of yesterday. Dr. Checko said that personal EHRs belong to the individual and not Medicaid, and that the role should be discussed.

Dr. Agresta said that the more recent discussions that were on the list were more relevant. He said that the presentation given by Tom Woodruff should be passed along to the other councils. He said that all of the discussion around Zato should be packaged into one document, because giving them the disparate forms would be confusing. Dr. Agresta said that the statewide council would need an update on what the status of the APCD is currently. He said that he has concerns for the advisory group if they meet once a month and materials are sent last minute, that that would not be as helpful or productive. Dr. Agresta mentioned that just giving them the information doesn't work, that they need to be digestible.

Dr. Villagra strongly seconded Dr. Agresta's point. He stated that the conclusions the HIT Council reached need to be summarized. Dr. Villagra said that there should be a summary document that summarizes lessons learned from the presentations. Ms. Skinner agreed with Victor Villagra and Thomas Agresta. She added that the work we the SIM HIT Council was charged with doing is now being handed over to the other group. She mentioned that the new council need to hear about the work this council did and understand how the work will support the efforts of the statewide council.

Mr. Dias made a comment on the depth of detail, where there were a number of discussions that persisted through a number of meetings; for example, the evaluation of the diabetes measure, Zato and the topics that persisted, and the focused discussions around evaluations and assessments and

presentations to raise awareness. Ms. Veltri responded to Mr. Dias by saying that we can draw on the minutes etc. to prepare that detail to present to that Council.

Dr. Villagra had one point for consideration: the APCD had close to 1 year of delay and considerable expense to tighten up policies regarding privacy. What the APCD did regarding privacy is not replicable from payer perspective, upstream (it's a strict standard). The privacy requirement does not cover the entire chain of custody of the data. Dr. Villagra said we need to think more systematically. He said in addition, to Dr. Checko's earlier point, it is important to have a system perspective and not a 'point in time' view.

Ms. Skinner added that the SIM HIT Council spent a lot of time circling on what its charge was. It should be clear to the new council what their role will be. Ms. Veltri noted that the onboarding of the HITO will assist with that prioritization.

Ms. Veltri closed this subject by telling attendees that if they think of any other suggestions or ideas, to please let her know.

9. Next Steps

In closing, Dr. Schaefer thanked everyone for their commitment of time and dedication of effort to this group. Ms. Veltri concurred.

Motion: to adjourn – Anthony Dias; seconded by Amanda Skinner.
Discussion: There was no discussion.
Vote: All in favor.

Action item

- Ms. Veltri requested that attendees to the Zato Demonstration who did not previously submit their comments, do so by June 24, 2016. She said that a reminder will be sent out, asking them to do so.
- Summary of the SIM HIT Council key findings be provided to the statewide HealthIT Advisory Council.

The meeting adjourned at 11:33 a.m.